

FILED FEB 15 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1630

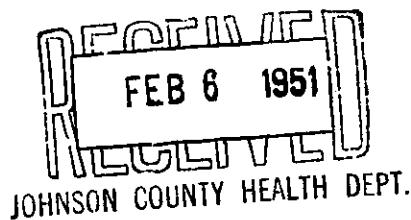
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BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 3165 PRIMARY REG. DIST. NO. 5611 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>JOHNSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>JOHNSON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>POST OAK TWN</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>POST OAK TWN</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <u>10 mi. SE of Warrensburg, Mo</u>	
3. NAME OF DECEASED a. (First) <u>DESDAMONA (DESSIE)</u> (Type or Print)		b. (Middle) <u>TOLER</u>	
c. (Last) <u>TOLER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 18 - 1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JAN 21 - 1871</u>
9. AGE (In years last birthday) <u>79</u> Months <u>11</u> Days <u>27</u>		11. BIRTHPLACE (State or foreign country) <u>MORGAN COUNTY, MO</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>ELZA DICE MARRIOTT</u>	
13b. MOTHER'S MAIDEN NAME <u>PHILENA CRAIG MARRIOTT</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN TOLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs LOUIS I. BAKER - RFD #3</u>		ADDRESS <u>WARRENSBURG, MO</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Diabetic mellitus</u> INTERVAL BETWEEN ONSET AND DEATH  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-15</u> , 19 <u>50</u> , to <u>1-17</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1-17</u> , 19 <u>51</u> , and that death occurred at <u>5:25 A. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>R. Lee Cooper M.D.</u>		23b. ADDRESS <u>Warrensburg, Mo.</u>	
23c. DATE SIGNED <u>1-18-51</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>JAN 21-1951</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>VERSAILLES CITY CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>VERSAILLES, MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>Jan 18 1951</u>		REGISTRAR'S SIGNATURE <u>148</u>	
FURNAL DIRECTOR'S SIGNATURE <u>W. F. Redwell</u>		ADDRESS <u>Versailles, Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

working under my personal supervision. \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.